MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

★ 10196

Reg. Diat. No. 142

1. PLACE OF DEATH:
County: Prince George
City or town: Hillside md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Hillside
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5207 L. St Hillside md
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: CHRISTINA C. ALESANDRELLI

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Paul alesandrelli
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 2-1855

8. AGE: Years	Months	Days	If less than one day
91			..... hrs. ..... min.

9. Birthplace: Italy (Town, county, and state)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: Pasquarle meglio
13. Birthplace: Italy

MOTHER
14. Maiden name: Maria D. Cucanelli
15. Birthplace: Italy

16. Informant: Guissippi Alesandrelli
Address: 5202 L St. Hillside md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-25-46 (month) (day) (year)
Cemetery or crematory: Mt. Olivet.
Location: Washington, D.C.

19. Funeral director: U.S. E. Chambers Co.
Address: 517 11th St. S.E.

19. Oct. 24 1946 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 22 1946, at 5-15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 22 1944, to Oct 22 1946
and that I last saw h.. alive on Oct. 22 1946

Immediate cause of death	DURATION
Acute Cardiac Dilatation	2 hrs
Chronic Interstitial Nephritis	6 mos
Due to: Generalized sclerosis.	
Due to:	
Other conditions: Generalized Arterio-Sclerosis.	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — — — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work? —

23. SIGNATURE: Harry J Crawford M D
M. D. or other
Address: 816 E St. N E Date signed: Oct 22 44

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

10197

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Chapel Oaks
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Newborn
Hospital, Institution, or street address where death occurred:
5404 Nash St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Chapel Oaks
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5404 Nash St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Victor Lee Arrington

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 25, 1946

8. AGE: Years: Newborn | Months | Days | If less than one day: 3 hrs. 45 min.

9. Birthplace: Chapel Oaks, Prince Geo., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Robert Lee Arrington
13. Birthplace: Madison, Va.

MOTHER
14. Maiden name: Hazel Estelle Bleday
15. Birthplace: Madison, Va.

16. Informant: Mrs. Hazel E. Arrington
Address: 5404 Nash St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 26 46 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Washington D.C.

18. Funeral director: J. B. Johnson
Address: Annapolis Md.

19. Oct. 26 1946 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25 1946 at 6 30 P M

21. I CERTIFY that death occurred on the ~~date~~ above stated; that I attended deceased from Oct. 25 1946 to Oct. 25 1946 and that I last saw h~~im~~ alive on Oct. 25 1946

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John W Robinson M.D. M. D. or other
Address: 1201 Eastern Ave Balto Date signed: 10/25/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
OCT 29 1946
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10198

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Suitland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Innocent

Hospital, Institution, or street address where death occurred: Hydrographic Office

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1343 - Locust Road NW

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Reid Samuel Baker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Frances Baker

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): April 22, 1883

8. AGE: Years: 63 Months: Days: If less than one day: hrs. min.

9. Birthplace: Jackson Summit, Penn. (Town, county, and state)

10. Usual occupation: Draftsman

11. Industry or business: U.S. Hydrographic Office

FATHER — 12. Name: Irvin J. Baker

FATHER — 13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Clara B. Butts

MOTHER — 15. Birthplace: Conn.

16. Informant: Frances Baker

Address: 1343 Locust Road NW DC

17. (Burial, cremation, or removal. Which?) Date thereof: Oct 7 46 (month) (day) (year)

Cemetery or crematory: Washington D.C.

Location

18. Funeral director: Joe Gawler's Sons

Address: 1756 Penn ave. N.W.

19. (Date rec'd by registrar) 10-7-46 Thos D Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 7 19 46, at 9 29 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary thrombosis	
&	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE: Deputy medical Examiner James J. Bond M. D. or other

Address: Forestville Md Date signed 10-7-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 10199

Reg. Dist. No. 2431

1. PLACE OF DEATH:
County: Prince George's
City or town: (Rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos., 10 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 3 mos., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 925 - O. Street N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: BANKS, CLIMMIE

3.(b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Paul Banks
6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): October 27, 1922

8. AGE: Years	Months	Days	If less than one day
24	-	2	...hrs. ...min.

9. Birthplace: Caroline, Virginia
(Town, county, and state)
10. Usual occupation: Bake Shop Employee
11. Industry or business:

FATHER
12. Name: Leroy Monroe
13. Birthplace: Caroline, Virginia

MOTHER
14. Maiden name: Rosalie Samuels
15. Birthplace: Caroline, Virginia

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10/31/1946 (month) (day) (year)
Cemetery or crematory: D.C. Morgue
Location: Wash D C

18. Funeral director: -
Address: -

19. Oct 29 1946 (Date rec'd by registrar) Rowland S Phibbs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 29, 1946, at 6.50 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/19 1946, to 10/29 1946
and that I last saw her alive on 10/29 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ...Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed 10/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2430

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

(S) 10200

Reg. Dist. No. 234

1. PLACE OF DEATH:

County: Prince Georges

City or town: Fort Washington, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 8 days

Hospital, Institution, or street address where death occurred:
Veterans Administration Hospital

How long in hospital or institution? 4 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County: ---

City or town: Manassas
(If outside city or town limits, write RURAL and give nearest town)

Street No. ---
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American War ✓

3.(a) FULL NAME: BEAVERS, Robert A.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 14, 1867

8. AGE: Years	Months	Days	If less than one day
79	5	8	..... hrs. ..... min.

9. Birthplace: Manassas, Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ---

FATHER
12. Name: John Beavers
13. Birthplace: Brestsville, Virginia

MOTHER
14. Maiden name: Virginia Davis
15. Birthplace: Independence Hill, Virginia

16. Informant: Hospital Records
Address: Fort Washington, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10-23-46 (month) (day) (year)

Cemetery or crematory: Manassas, Va.

Location .....

18. Funeral director: George D. Baker and Son
Address: Manassas, Virginia

19. Oct 23 1946 Mrs Alton Davis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 1946, at 11:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1946, to October 22 1946
and that I last saw him alive on October 22 1946

	DURATION
Immediate cause of death: Cerebral Softening	6 mos. (?)
Due to: Arteriosclerosis, cerebral	years (?)
Due to:	
Other conditions: Coronary Arteriosclerotic Heart Disease	Years (?)

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op. ----

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of ---

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----

Means of injury Injured at work?

23. SIGNATURE: Ingram C. Taylor M.D.
INGRAM C. TAYLOR, M.D., Attending Physician, or other
Address: Ft. Washington, Maryland Date signed: 10-23-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10201

Reg. Dist. No. 242.

1. PLACE OF DEATH:

County: Prince George's

City or town: Fort Washington, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 days

Hospital, institution, or street address where death occurred:
Veterans Administration Hospital

How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 220 7th Street, S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: BOHANNON, Philip

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B.(b) Name of husband or wife: Annie Fletcher (Deceased)

B.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): December 7, 1888

8. AGE: Years	Months	Days	If less than one day
57	10	--	...hrs. ...min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER
12. Name: William Bohannon
13. Birthplace: Virginia

MOTHER
14. Maiden name: Sue Lear ?
15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Fort Washington, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/9/46 (month) (day) (year)

Cemetery or crematory: Arlington Memorial

Location: Arlington, Virginia

18. Funeral director: W. W. Chambers Co.

Address: 517 11th St, SE, Washington, D. C.

19. Oct. 9 1946 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1946, at 10 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 12 1946, to October 7 1946 and that I last saw him alive on October 7 1946

	DURATION
Immediate cause of death: Tuberculosis, pulmonary	3 to 6 months
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.:

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Chas P Benson MD
CHAS. P. BENSON, M.D., Acting C.M.O.

Address: Ft. Washington, Maryland Date signed: 10-7-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

★ 10202

Reg. Dist. No. 239

1. PLACE OF DEATH:
County Prince George
City or town Laurel, Md (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 82
Hospital, institution, or street address where death occurred:
—
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Laurel, Md (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Old Gunpowder Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Bond

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Clarence Bond
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1864

8. AGE: Years	Months	Days	If less than one day
82	1		..... hrs. ..... min.

9. Birthplace Laurel, Md. (Rural)
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home
FATHER 12. Name John Turner
13. Birthplace Lexington Kentucky
MOTHER 14. Maiden name Elizabeth Caggas
15. Birthplace Caggsville, Md.
16. Informant
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 11 1946 (month) (day) (year)
Cemetery or crematory Bond Family Cemetery
Location Laurel, Md. (Rural)
18. Funeral director De Witt Donaldson
Address Laurel, Md.
19 Oct 10 1946 M. Brashears
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 8 1946, at 6:52 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 3 1946, to 10 8 1946
and that I last saw her alive on 10 4 1946

Immediate cause of death	DURATION
Apoplexy Cerebral hemorrhage	1 d.
Due to Hig Blood Pressure	5 yrs.
Due to Mass left chest	6 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B A Warren M. D. or other
Address Laurel Md Date signed 10-8-46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10203

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George
City or town: Hyattsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? July 24, 1942
Hospital, institution, or street address where death occurred:
Sacred Heart Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: —
City or town: Balto.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2818 E. Balto St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Joseph Bonomo

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife: Carmella Palazardo
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 3, 1871

8. AGE: Years	Months	Days	If less than one day
75			..... hrs. ..... min.

9. Birthplace: Italy
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Salvatore Bonomo
13. Birthplace: Italy.

MOTHER
14. Maiden name: Salvatora Glorio
15. Birthplace: Italy

16. Informant: Mr. Frank G. Bonomo
Address: 6903 Tuxedo Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 14 46 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Belair Rd.

18. Funeral director: F. V. Pipitone
Address: 2818 E. Balto St.

19. 10/11/46 19.....
(Date rec'd by Registrar)
A. W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 19 46, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to October 10 19 46
and that I last saw him alive on October 10 19 46

Immediate cause of death	DURATION
Coronary thrombosis	3 days
Due to: Hypertensive Heart disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Thomas F. Collins M.D.
M. D. or other
Address: 333 H St NE Washington D.C. Date signed: Oct 10 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 10284 289

1. PLACE OF DEATH: County Prince Geo Laurel Md

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Virginia County

City or town Alexandria (If outside city or town limits, write RURAL and give nearest town)

Street No. 3121 Martha Custis Drive (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME THOMAS WEST BOURNE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 27, 1946

8. AGE: Years	Months	Days	If less than one day
	1	1	hrs. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name William C. Bourne

13. Birthplace Nashville N.C.

MOTHER 14. Maiden name Emily C. Battle

15. Birthplace Tarboro N.C.

16. Informant William C. Bourne

Address 3121 Martha Custis Dr. Alex. Va.

17. (Burial, cremation, or removal. Which?) (Removal) Burial Date thereof Oct. 30, 1946 (month) (day) (year)

Cemetery or crematory George Washington Mem. Park

Location Rippon Blvd. Prince Geo. Co. Md.

18. Funeral director W. W. Chambers Co

Address 1400 Chapin St. N.W. Wash D.C.

19. Oct 28 1946 M. Brashears (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28-46 1946, at 3 55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Atelectasis	1 day
Due to Osteogenesis imperfecta	
Due to Congenita	1 mo
Other conditions Atelectasis Hyaline membrane disease	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Vasilios J. Lambros M.D. M. D. or other

Address 1029 Vermont Ave. NW Date signed 10-28-46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (946)

CERTIFICATE OF DEATH

Reg. Dist. No. 2152 — 102710

1. PLACE OF DEATH:
County: Queen Annes
City or town: Centreville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Annes
City or town: Centreville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Albert Bowser

3.(b) Social Security Number: 214-18-4290

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Sarah Phillips Bowser
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): June 24-1889

8. AGE: Years: 57 Months: 4 Days: 7 If less than one day: hrs. min.

9. Birthplace: Centreville Q.A.Co. Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Horace Bowser
13. Birthplace: Centreville Q.A.Co. Md

MOTHER
14. Maiden name: Annie Chew
15. Birthplace: Q.A.Co. Maryland.

16. Informant: Sarah Bowser
Address: Centreville. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov-3-46 (month) (day) (year)
Cemetery or crematory: Chesterfield
Location: Centreville Maryland

18. Funeral director: Baston Bros
Address: Centreville, Maryland

19. 11-1-1946 (Date rec'd by registrar) Elsie Armstrong Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 31- 1946 at 7.30 P M

I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 24 1946 to Oct 31- 1946 and that I last saw h. alive on Oct. 31- 1946

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. Henry Fosler M. D. or other
Address: Centreville Md Date signed: Nov 1. 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1910)

CERTIFICATE OF DEATH

10205

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Prince Georges
City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Years
Hospital, Institution, or street address where death occurred:
3805 - Quincy Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3805 - Quincy Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Fredrick Bopwell Sr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Married

6.(b) Name of husband or wife Alice Bopwell
6.(c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Oct 3, 1890

8. AGE:	Years	Months	Days	If less than one day
	56			hrs. min.

9. Birthplace Winchester, Va
(Town, county, and state)
10. Usual occupation Policeman
11. Industry or business Co. Police
FATHER 12. Name Aaron H. Bopwell
13. Birthplace Virginia
MOTHER 14. Maiden name Susanna Davidson
15. Birthplace Virginia
16. Informant John H. Bopwell Jr.
Address 3805 Quincy St, Brentwood Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 2. 1946 (month) (day) (year)
Cemetery or crematory Mount Hebron
Location Winchester, Va
18. Funeral director Jones Funeral Home
Address Winchester, Va.
19. Oct 2 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1946, at 10:30 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Acute Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Deputy medical Examiner
23. SIGNATURE John D. Ford M. D. or other
Address T.U. Pastille md Date signed 10-2-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-f)

10206

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:
County Prince Georges
City or town Seat Pleasant (If outside city or town limits, write RURAL and give nearest town) M.D.
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Seat Pleasant (If outside city or town limits, write RURAL and give nearest town)
Street No. 215 - Addison Rd. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Louise A. Boyer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ John A. Boyer
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Nov. 16. 1872

8. AGE: Years	Months	Days	If less than one day
73	10	14	17 hrs. 27 min.

9. Birthplace Oldenberg Germany (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. Name of FATHER Augustus Yarner
13. Birthplace Germany
14. Maiden name of MOTHER Unknown
15. Birthplace
16. Informant Richette L. Hoover
Address 200-69th St. Seat Pleasant
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-31-46 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Pr. Geo. Co. Md.
18. Funeral director J. Wm. Lee's Sons
Address 300 - 4th St. N.E.
19. Oct. 29 1946 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1946, at 5:29 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Past Ten Years to 19..... and that I last saw h[illegible] alive on Oct. 28th 1946
Immediate cause of death Cancer of Liver — DURATION 3 mos.
Due to Pulmonary Edema — 24 hrs.
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. L. Morgan M.D. on other
Address Seat Pleasant Md. Date signed Oct. 28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Certificate approved
by the Prince Georges
County Medical Examiner,
Dr James T. Boyd
Forestville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (934)

CERTIFICATE OF DEATH

Reg. Dist. No. 10207 231

1. PLACE OF DEATH:
County: Prince Geo. Co.
City or town: Bladensburg. md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Pr. Geo. Co.
City or town: Bladensburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Vincents Trayler Camp
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Horace Grover Brient

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mary anne Brient
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug. 28 - 1887

8. AGE: Years	Months	Days	If less than one day
59			..... hrs. ..... min.

9. Birthplace: Dayton, Ohio (Town, county, and state)
10. Usual occupation: Building Contractor
11. Industry or business: own business
FATHER 12. Name: Horace M. Brient
13. Birthplace: Tenn
MOTHER 14. Maiden name: Naomi Jett
15. Birthplace: Ohio
16. Informant: Mary Anne Brient
Address: Bladensburg. md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-15-46 (month) (day) (year)
Cemetery or crematory: Wash. National
Location: Suitland. md
18. Funeral director: W W Chambers Co.
Address: Riverdale. md.
19. Oct 14 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 12 1946, at 10 45 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 7 1943 to Oct 12 1946 and that I last saw him alive on Oct 7 1946

Immediate cause of death	DURATION
Coronary Heart attack	Sudden
Due to: Arteriosclerotic Heart Disease	3 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: L W Malin MD
M. D. or other
Address: Riverdale, Md. Date signed 10-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10208

Reg. Dist. No. 2431

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 66 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 66 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Washington County:
City or town: D. C. (If outside city or town limits, write RURAL and give nearest town)
Street No. 470 G. Street, S. W. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME BRIGHT JUANITA
3.(b) Social Security Number

4. Sex: female
5. Color or race: colored
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): September 4, 1918

8. AGE:	Years	Months	Days	If less than one day
28	28	1	8	... hrs. ... min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business

FATHER
12. Name: James Bright
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Edna Olds
15. Birthplace: Washington, D. C.

16. Informant: Deceased
Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof Oct 12, 1946 (month) (day) (year)
Cemetery or crematory
Location: Washington, D.C
18. Funeral director: Barnes & Matthews
Address: 614-4th St. S.W.
19. Oct 13 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 12 1946, at 3:20 a. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/17 1946, to 10/12 1946
and that I last saw her alive on 10/12 1946

	DURATION
Immediate cause of death: pulmonary Tuberculosis	7 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale, Md. Date signed: 10/12/46

2-25

2-2430

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-6)

CERTIFICATE OF DEATH

10209

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Price Georges
City or town: Glenn Dale (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 214 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 214 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington, D. C. (If outside city or town limits, write RURAL and give nearest town)
Street No. 1415 17th Street, N. W. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Nettie T. Brown

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 20, 1927

8. AGE:	Years	Months	Days	If less than one day
	18	10	14	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Student
11. Industry or business

FATHER
12. Name: Charles Brown
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Arminta Hamilton
15. Birthplace: Washington, D. C.

16. Informant: Deceased
Address:

17. REMOVAL Oct 4 1946 (Burial, cremation, or removal. Which?) Date thereof Oct 4 1946 (month) (day) (year)
Cemetery or crematory:
Location: Occoquan, Va.
18. Funeral director: F. Galesh & Son.
Address: Hyattsville, Md.

19. Oct. 4, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4 1946 145 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/27/46 1946 to 10/4/ 1946 and that I last saw her alive on 10/4/ 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 yr 2 mos
empyema, left, tuberculous	11 mos
Due to:	
Cerebral infarct, probably	1 mo 1 da
Due to: tuberculous	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 10/4/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 1021() 231

1. PLACE OF DEATH:
County: Pr. Georges
City or town: Chenerly (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred: Pr. Georges Hosp.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: Hyattsville (If outside city or town limits, write RURAL and give nearest town)
Street No. 3925 Livingston Rd. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bruehl, Mr. Henry J.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife: Mrs. Frieda Bruehl
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Dec. 12 - 1879

8. AGE: Years	Months	Days	If less than one day
66			hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Edward Bruehl
13. Birthplace: Germany

MOTHER
14. Maiden name: Clara Weinerb
15. Birthplace: Germany

16. Informant: Hospital Records
Address: Chenerly Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 19-46 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Wash. D.C.
18. Funeral director: W. W. Chambers Co.
Address: Riverdale Md.
19. 10/17 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-17-1946, at 3:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-10 1946 to 10-17 1946
and that I last saw h.. alive on 10-16 1946

Immediate cause of death	DURATION
Cerebral Laceration Hemorrhage	
with fracture of the base.	
Due to Accidental Fall.	
Due to	
Other conditions Arteo-sclerosis of the Heart	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Sname.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert Wolf M.D. or other
Address: Hyattsville Md. Date signed: 10/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

10213 232

Reg. Dist. No.

1. PLACE OF DEATH:

County: Prince George's

City or town: Rural - Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Pr. Geo.

City or town: Rural - Upper Marlboro, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3 miles north Upper Marlboro
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Burroughs

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 11, 1946

8. AGE: Years — | Months — | Days — | If less than one day: 2 hrs. — min.

9. Birthplace: Upper Marlboro, Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER
12. Name: John William Burroughs
13. Birthplace: Croome, Maryland

MOTHER
14. Maiden name: Annie Steward Sweeney
15. Birthplace: Washington, D.C.

16. Informant: Annie Burroughs
Address: Upper Marlboro, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-12-46 (month) (day) (year)

Cemetery or crematory: St. Thomas

Location: Croom, Md.

16. Funeral director: Ritchie Brothers

Address: Upper Marlboro, Md.

19. Oct 12 1946 (Date rec'd by registrar) E. Ed Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 Oct 46 19 46, at 2 o'clock P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11 Oct 19 46, to 11 Oct 19 46 and that I last saw her alive on 11 Oct 46 19

Immediate cause of death	DURATION
Atelectasis	2 hr.
Due to: Prematurity	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R B Lasser M D
M. D. or other

Address: Upper Marlboro Date signed 11 Oct 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

★ 10212

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges

City or town District Heights Md. 205 Ave D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years

Hospital, institution, or street address where death occurred 205 Ave D - Dist Heights Md. Washington 19 DC

How long in hospital or institution? — none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Pr. Georges

City or town Washington 19 DC.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 205 Ave D. District Heights Md.
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Mary Ellen Carnes

3.(b) Social Security Number —

4. Sex Fem. 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed.

6.(b) Name of husband or wife Samuel L Carnes.

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) March 23 1863

8. AGE: Years 83 Months Days If less than one day ... hrs. ... min.

9. Birthplace Luckets - Louden Co, Va.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business at home

FATHER 12. Name Julius F. Frey.

13. Birthplace Virginia.

MOTHER 14. Maiden name Catherine Eliz. Hefner.

15. Birthplace Virginia

16. Informant Pearl Owens

Address 205 Ave D - Dist Heights Md

17. Burial Date thereof Oct. 25. 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Pleasant Cemetery

Location Taylorstown Louden Co. Va

18. Funeral director J. William Lee's Sons Co

Address 300 - 4th St. N. E.

19. 10-23 1946 Thos D Griffith Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1946, at 7:45 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1940, to Oct 22 1946

and that I last saw her alive on Oct 21 1946

	DURATION
Immediate cause of death Acute myocardial failure	1 hr.
Due to Chronic Endocarditis and Myocarditis	unknown over 5 years
Due to Gen'l Arteriosclerosis.	unknown
Other conditions — none of note —	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide — Date of —

Where did injury occur? —
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE Paul C Van Natta M. D. ~~other~~

Address Washington 19 DC Date signed Oct 22 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-A)

10213

CERTIFICATE OF DEATH

Reg. Diat. No. 280

1. PLACE OF DEATH:

County Prince Georges

City or town Bettsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Bettsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Miron Simms Cassard

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1876

8. AGE: Years 70 Months Days If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Truckster

11. Industry or business

FATHER 12. Name Jerimiah Cassard

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Simms

15. Birthplace Maryland

16. Informant Miss Sadie Jones

Address Bettsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 22. 1946 (month) (day) (year)

Cemetery or crematory St. Johns

Location Bettsville Md

18. Funeral director J Gaeke & sons

Address Hyattsville Md.

19. October 22 1946 (Date rec'd by registrar) John D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1946, at 6 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19, to 19

and that I last saw h alive on 19

Immediate cause of death Acute Congestive heart failure — DURATION

Due to Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner James D. Bond M. D. or other

Address Hyattsville Md Date signed 10-21-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

10214

Reg. Dist. No. 242

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45-15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Tuxedo Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
705 - 59 - Pl. N.E.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Geo.
City or town: Tuxedo Hghts.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 705 - 59 Pl. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: James Clinton Clark

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mary E. Clark
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years: 68 ? | Months | Days | If less than one day: hrs. min.

9. Birthplace: Upper Marlboro. (Town, county, and state)
10. Usual occupation: Farmer.
11. Industry or business: Farming.

MOTHER
12. Name:
13. Birthplace: Unk

FATHER
14. Maiden name: Unk.
15. Birthplace:

16. Informant: Mary E. Clark
Address: 705 59 - Pl. N.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 5 46 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Washington D.C.
18. Funeral director: B. Johnson
Address: Annapolis Md.

19. Oct. 4. 1946 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 2 19 46 at 4.00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 19 46 to Oct. 2 19 46 and that I last saw h alive on Oct. 2 19 46

	DURATION
Immediate cause of death: Hypertensive	
Due to: Cardio-Vascular	?
Due to: Disease.	
Due to:	
Other conditions: Arteriosclerosis	?
Hostatism.	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. C. Beldon M. D. or other
Address: 1423 - H Street N.W. Date signed: 10.4.46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(13b) ★ 10215 /

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 mos., 2 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 10 mos., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1337 - Que St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: THOMAS A. COSTELLO

3.(b) Social Security Number: 151-14-6412

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 25, 1901

8. AGE: Years	Months	Days	If less than one day
44	11	4	hrs. min.

9. Birthplace: Cuba
(Town, county, and state)
10. Usual occupation: Delivery Boy
11. Industry or business:
FATHER 12. Name: Thomas Costello
13. Birthplace: Cuba
MOTHER 14. Maiden name: Bessie Robinson
15. Birthplace: Cuba
16. Informant: Decedent
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11 - 2 - 46 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Washington D.C.
18. Funeral director: Carey & Latney
Address: 611 - 5th St. N. W.
19. Oct. 29, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 29, 1946 at 4:05 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 27, 1945, to Oct. 29 1946
and that I last saw h... alive on Oct. 29 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	13 mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 10/29/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(H) MARGIN RESERVED FOR BINDING

2-25

2-2430

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10216

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges Co.

City or town: Glenn Dale - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 10 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 month, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 228- Oakdale Pl., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: CHRISTINE DAVIS

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife: Alton H. Davis

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): Dec. 5, 1919

8. AGE: Years	Months	Days	If less than one day
26	10	1	...hrs. ...min.

9. Birthplace: Union, South Carolina
(Town, county, and state)

10. Usual occupation: waitress

11. Industry or business: -

FATHER
12. Name: Arigh Smith
13. Birthplace: ?, South Carolina

MOTHER
14. Maiden name: Lillian Smith
15. Birthplace: ?, South Carolina

16. Informant: deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10 7 46 (month) (day) (year)

Cemetery or crematory

Location: to Washington, D.C.

18. Funeral director: Robinson Co.

Address: 1342-4½ St. N.W.

19. Oct. 7 1946 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 7, 1946, at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 27, 1946, to Oct 7, 1946 and that I last saw h... alive on Oct. 6, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6½ mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Right tubo-ovarian abscess following pregnancy Date of op. 6/7/46
following pregnancy & delivery 3/18/46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md., Date signed 10/7/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(★) 16217

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Geo. Co.
City or town Ardmore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County Pr. Geo.
City or town Ardmore
(If outside city or town limits, write RURAL and give nearest town)
Street No. Ardwick Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Susie W. Dollar

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife Albert A. Dollar
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 28 - 1873

8. AGE: Years	Months	Days	If less than one day
73			..... hrs. ..... min.

9. Birthplace Linden N.C. (Town, county, and state)
10. Usual occupation Home maker
11. Industry or business
FATHER 12. Name Harold Hobbs
13. Birthplace N C
MOTHER 14. Maiden name Susan Doctor
15. Birthplace N.C.
18. Informant E. Edwin Dollar
Address Ardwick Rd. Ardmore, md
17. Buried (Burial, cremation, or removal. Which?) Date thereof 10/19/46 (month) (day) (year)
Cemetery or crematory Dunn Cemetery
Location Dunn N.C.
18. Funeral director W W Chanks Co
Address Riverdale - md
19. 10/19 1946 Amanda Dunn
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 18 1946 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to Oct 18 1946 and that I last saw h.. alive on Oct 15th 1946

Immediate cause of death	DURATION
Carcinoma of Cervix Uteri	1 mo.
Due to	
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Dayton C Watkins MD (M. D. or other)
Address 5308 Annapolis Rd Hyattsville Date signed Oct 18-1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1519)

CERTIFICATE OF DEATH

★ 10218

Reg. Dist. No. 231

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County Prince George.
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5½ days
Hospital, institution, or street address where death occurred:
Prince George General Hospital
How long in hospital or institution? 5½

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince George
City or town Capitol Heights.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 826-57th Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Edwards.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	w	single

B.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 27- 1946

8. AGE: Years | Months 8 mo | Days | If less than one day hrs. min.

9. Birthplace D.C.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Wilbur Edwards.
13. Birthplace Va.

MOTHER 14. Maiden name Mary Miller
15. Birthplace Va.

16. Informant Mrs. Mary Miller Edwards.
Address 826-57th Capitol Hgts.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 8. 1946 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location colmar Manor Md
F Rascia sons

18. Funeral director
Address Hyattsville Md.

19. 10/8 1946 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH (October) 6 1946, at 11:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 2 1946, to October 6 1946
and that I last saw h... alive on October 6 1946

Immediate cause of death	DURATION
Dehydration & acidosis due to pyloroduodenal + acute gastroenteritis	2 wks
Due to	
Due to	
Other conditions Acute purulent otitis media	2 wks.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William Brauner M. D. or other
Address Capitol Hgts, Md. Date signed 10/3/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

10219

Reg. Dist. No. 245

1. PLACE OF DEATH:
County PRINCE-GEORGES
City or town MT. RAINIER
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 YRS.
Hospital, institution, or street address where death occurred:
4106 - 32nd ST. MT. RAINIER MD.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County PRINCE GEORGES
City or town MT. RAINIER.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4106 - 32 RD
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME CLARENCE John FOSTER.

3.(b) Social Security Number 578.09-8991

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MINNIE D.
6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) May 9, 1885.

8. AGE: Years 61 | Months 5 | Days — | If less than one day: 1 hrs. 60 min.

9. Birthplace BRADFORD-COUNTY-GRANVILLE (Town, county, and state) SUMMIT PENNA.

10. Usual occupation REVISOR OF PROOF ROOM

11. Industry or business EVENING STAR-Newspaper

FATHER
12. Name HIRAM H FOSTER
13. Birthplace GRANVILLE SUMMIT PA

MOTHER
14. Maiden name JULIA VROMAN
15. Birthplace BARLINGTON PA.

16. Informant BENJ. M LANKINI —
Address 4106 - 32nd ST MT. RAINIER MD.

17. Burial, cremation, or removal. Which? Date thereof Oct 12, 1946 (month) (day) (year)
Cemetery or crematory CEMETERY-PROSPECT HILL
Location NORTH CAPITOL-ST. N.E. D.C.

18. Funeral director F. GASCH'S SONS
Address HYATTSVILLE MD.

19. Oct 12" 1946 Mrs. Jas. Severe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10, 1946 at 1:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10, 1946 19 to September 26, 1946
and that I last saw him alive on September 26, 1946

	DURATION
Immediate cause of death: Toxemia	one week
Due to: Carcinoma of Cecum with generalized metastasis	several months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Cecum with generalized metastasis Date of op. 7-8-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

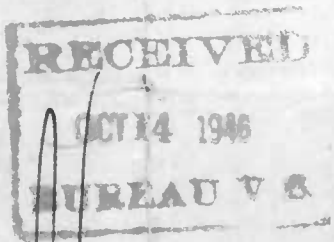
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Mt. Rainier Md. Date signed 10/11/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

★ 10220

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince George
City or town Cheverly Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Prince Geo. Gen. Hospital
How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 511 - 73rd St. N.E. Washington 19,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Fowler, Mrs. Irene

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	M

6.(b) Name of husband or wife Emmett Fowler
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1900.

8. AGE: Years	Months	Days	If less than one day
46			..... hrs. ..... min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual occupation H. W.
11. Industry or business

FATHER
12. Name Parker
13. Birthplace N.C.

MOTHER
14. Maiden name Saunders
15. Birthplace N.C.

16. Informant Mr. Emmett Fowler
Address as above.
17. Burial Date thereof Nov. 2, 1946
(Burial, cremation, or removal, which) (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Suitland, Md.
18. Funeral director J. Wm Leis Sons
Address 300 - 4" St. N.E.
19. 10/31 1946 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1946 at 11 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 15 1944 to October 31 1946
and that I last saw her alive on October 31 1946

Immediate cause of death	DURATION
Carcinoma of breast with metastases	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William Brannin M. D. or other
Address Capitol Hgts, Md Date signed 10/31/46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

10221 Reg. Dist. No. 239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince George.
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George.
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 322 Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Broad H. Root
3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Sept 24, 1865

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
81	1	4		

9. Birthplace: Laurel - Howard Co. Md.
(Town, county, and state)
10. Usual occupation: Retired Merchant
11. Industry or business: Grocery Store
FATHER 12. Name: Henry C. Root
13. Birthplace: Md.
MOTHER 14. Maiden name: Alberta Birdsall
15. Birthplace: Montgomery Co.
16. Informant: Ethel M. Root
Address: Laurel, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 30 1946 (month) (day) (year)
Cemetery or crematory: Gay Hill
Location: Laurel, Md.
18. Funeral director: W. H. Hall Undertaking Co.
Address: Laurel, Md.
19. Oct 30 1946 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28 1946, at 330 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3-16 1944, to Oct 28 1946
and that I last saw h... alive on Oct 28 1946

Immediate cause of death	DURATION
Intracerebral Hemorrhage	3 yrs
Major Cerebral	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. B. [illegible] M. D. or other
Address: 322 Main St Laurel Date signed: 10/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

CERTIFICATE OF DEATH

★ 10222

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1½ days.
Hospital, Institution, or street address where death occurred:
Prince George General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles County.
City or town: Riva
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Galloway, Mr. George Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	married.

6.(b) Name of husband or wife: Mrs. Victoria Galloway
6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): August 14- 1906

8. AGE: Years: 40 Months: 2 Days: 11 If less than one day: hrs. min.

9. Birthplace: Riva, Maryland.
(Town, county, and state)

10. Usual occupation: machinist

11. Industry or business

FATHER
12. Name: George Galloway
13. Birthplace: Maryland. Md.

MOTHER
14. Maiden name: Martha Castle
15. Birthplace: Maryland- Md.

16. Informant: Mrs Victoria Galloway
Address: Riva - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 28/46 (month) (day) (year)
Cemetery or crematory: Taylorsville Md
Location: Riva

18. Funeral director: B. E. Hopkins
Address: Annapolis. Md.

19. Oct 28 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-25 1946, at 1 20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to Crushed chest and crushed abdomen	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 10-24-46
Where did injury occur? Landover (City or town) P.G. (County) Md. (State)
Injured at home, farm, industry, public place (where?): State Road
Means of injury: Driving Auto Injured at work? No
Reports Medical Examiner

23. SIGNATURE: ..... M. D. or Other
Address: Forestville Md Date signed 10-25-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (MC)

10223

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Dist. of Columbia Geo. Co
City or town Chevery, md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Dist of Columbia
City or town Wash. D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3612 - 18th N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Albert J. Gezelle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Wh	married

6.(b) Name of husband or wife Julia J. Gezelle
6.(c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) May 4 - 1896

8. AGE: Years	Months	Days	If less than one day
50			hrs. min.

9. Birthplace Belgium (Town, county, and state)
10. Usual occupation Painter
11. Industry or business

FATHER	12. Name	Cornelious Gezelle
	13. Birthplace	Belgium
MOTHER	14. Maiden name	—
	15. Birthplace	Belgium

16. Informant Julia J. Gezelle
Address 3612 - 18th N.E. Wash D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 - 30 46 (month) (day) (year)
Cemetery or crematory Arlington Natl.
Location Arlington Va.
18. Funeral director L.W. Chauncey Co.
Address Riverdale, md
19. 10/28 1946 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1946, at 7:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Compression fracture of spinal cord	
Due to Fracture and dislocation of Second and Third Cervical Vertebra	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 10-27-46
Where did injury occur? Cottage City P.G. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Route #1
Means of injury Pedestrian Struck Injured at work? No
Deputy Medical Examiner
23. SIGNATURE James J. [illegible] M. D. or other
Address Hyattsville Md Date signed 10-28-46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10224

CERTIFICATE OF DEATH

Reg. Dist. No. 2430

1. PLACE OF DEATH:
County: P. Geo.
City or town: Bowie. Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): 40 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: P. Geo.
City or town: Bowie, Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: —
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: William Fletcher Harding

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) ~~Name of husband~~ or wife: Augusta E. Harding
6(c) If alive, give age: over 40 years

7. Birth date of deceased (mo., day, yr.): Jan. 17, 1876

8. AGE: Years	Months	Days	If less than one day
70	9	27	— hrs. — min.

9. Birthplace: near Patuxent, Md
(Town, county, and state)
10. Usual occupation: Farming
11. Industry or business: Farming
FATHER — 12. Name: Thomas Franklin Harding
FATHER — 13. Birthplace: A. A. Co. Md.
MOTHER — 14. Maiden name: Rachael Waters
MOTHER — 15. Birthplace: A. A. Co. Md.
16. Informant: Augusta E. Harding.
Address: Bowie. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 16. 1946 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Washington D.C.
18. Funeral director: L. Gaeche's Sons
Address: Hyattsville Md.
19. Oct 16 1946 (Date rec'd by registrar) Mrs. J. W. Yingling (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14th 1946, at 6:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12th 1942, to Oct. 14 1946, and that I last saw h[illegible] alive on Oct. 13 1946.

Immediate cause of death	DURATION
Carcinoma of the rectum. (Post Operative Colostomy)	4 yrs 4 mo. 14 days.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: —
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. Lancaster M.D.
M. D. or other
Address: Bowie Date signed 10/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

★ 10225

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, RURAL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 11 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 513- 14'th St., N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: Regina M. Hines

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Harold C. Hines
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): June 16, 1922

8. AGE: Years	Months	Days	If less than one day
24	3	25	...hrs. ...min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: -

FATHER
12. Name: Patrick Harnan
13. Birthplace: Wilkesberry, Pa

MOTHER
14. Maiden name: Helen Finn
15. Birthplace: Wilkesberry, Pa.

16. Informant: deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct 11-1946 (month) (day) (year)
Cemetery or crematory
Location: to Washington D.C

18. Funeral director: Albert Fisher
Address: 64-H. St N.E. Wash. D.C.

19. Oct 11 1946 (Date rec'd by registrar) Rowland C. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 11, 1946, at 2.45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31, 1946, to Oct. 11, 1946
and that I last saw h...ed alive on Oct. 10, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	17 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 10/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2430

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1601E

CERTIFICATE OF DEATH

10220

Reg. Dist. No. 239

1. PLACE OF DEATH:
County Prince George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State — County —
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Baby Girl Wilson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 2, 1946

8. AGE: Years | Months | Days | If less than one day: 6 hrs. min.

9. Birthplace Hospital Laurel Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER — 12. Name Bernard N. Wilson
13. Birthplace Washington D.C.

MOTHER — 14. Maiden name Queenie P. ~~Hall~~ Murphy
15. Birthplace Howard Co. Md.

16. Informant Mrs. Bernard N. Wilson
Address Laurel Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 4 1946 (month) (day) (year)
Cemetery or crematory Emanuel Cemetery
Location Baltimore Md.

18. Funeral director W. Watts Henderson
Address Laurel Md.

19. Oct 4 1946 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1946 at 7 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 2 1946 to Oct 4 1946
and that I last saw her alive on Oct 4 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Instrumental delivery	
Maternal Diabetes	
Due to Postpartum Atelectasis	
Contracted Pelvis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE B Adams M. D. or other
Address Laurel Md. Date signed Oct 4 46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

10227

Reg. Dist. No. 242

M

I

T

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Prince George
City or town: Suitland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1½ years
Hospital, institution, or street address where death occurred: 4722 Huron Ave SE.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Suitland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4722 - Huron Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: GLORIA LYNNE HUFFMAN.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	

6.(b) Name of husband or wife: ✓

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 24-44

8. AGE:

Years	Months	Days	If less than one day
2		2	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: ✓

11. Industry or business: ✓

FATHER
12. Name: Melvin B. Huffman
13. Birthplace: Page Co., Va.

MOTHER
14. Maiden name: Erma Mae Jones
15. Birthplace: Washington, D.C.

16. Informant: Melvin B. Huffman
Address: 4722 Huron Ave SE

17. Burial. Date thereof: Oct. 29-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland Road S.E. Md.

18. Funeral director: D. H. Hines Co.
Address: 2901-14th St., N.W. (Washington, 9) D.C.

19. Oct. 26 1946 Carrie F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 26 1946, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 23, 1946, to Oct. 26 1946
and that I last saw h.er alive on Oct. 25 1946

	DURATION
Immediate cause of death: Anemia.	
Due to: Lymphocytic Leukemia	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Thibadeau M.D.
M. D. or other
Address: 3113 Ala. Ave. S.E. Wash., D.C. Date signed 10-26-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (934)

CERTIFICATE OF DEATH

★ 10228

Reg. Dist. No. 945

1. PLACE OF DEATH:
County PRINCE GEORGE Co.
City or town HYATTSVILL MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 DAYS.
Hospital, institution, or street address where death occurred:
MOTHER JONES REST HOME
How long in hospital or institution? SAME

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County —
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1503 - 19th St. SE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MAGIE CELESTE HERBERT

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOWED

6.(b) Name of husband or wife
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 30 - 1871

8. AGE: Years	Months	Days	If less than one day
75	MAR	30	..... hrs. ..... min.

9. Birthplace SANT MARRY CO, MD.
(Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name unknown
13. Birthplace " "

MOTHER
14. Maiden name unknown
15. Birthplace " "

16. Informant L. M. BURGESS
Address RIDGE ROAD HYATTSVILL MD

17. removal
(Burial, cremation, or removal. Which?)
Date thereof Oct. 30 1946
(month) (day) (year)

Cemetery or crematory
Location 317 Pa. Ave. Washington D.C.
18. Funeral director James T. Ryan Inc.
Address 317 Pa Ave S.E. D.C.

19. Oct 30 1946 Mrs Jas. Devere
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1946, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 23 1946, to October 30 1946
and that I last saw h.. alive on October 23 1946

	DURATION
Immediate cause of death Chronic Myocarditis	Several years
Due to Senility	Several years
Due to Arteriosclerosis	Several years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE W. Allen Griffith M. D. or other
Address Berwyn Md Date signed 10/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10222310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Prince Georges General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Mt. Rainier (If outside city or town limits, write RURAL and give nearest town)
Street No.: 4010-29th. Street (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George T. Hutton

3.(b) Social Security Number: 436-05-2668

4. Sex	5. Color or race	6.(a) Single, Married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 5, 1874

8. AGE: Years	Months	Days	If less than one day
72 yrs.			..... hrs. ..... min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Jerome Hutton
13. Birthplace: Washington, D.C.

MOTHER — 14. Maiden name: Clementine Anderson
15. Birthplace: Washington, D.C.

16. Informant: Mrs. Eolia Ward (Sister)
Address: 4010-29th. Street, Mt. Rainier

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 4, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Washington, D.C.

18. Funeral director: Wm. J. Walker
Address: 3200-R.I. Ave. Mt. Rainier, Md.

19. Nov 3 1946 (Date rec'd by registrar) Amanda Dabney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-31 1946 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-13 1946 to 10-31 1946 and that I last saw h.. alive on 10-31 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 hours
Due to Hypertension Cardio Vascular Disease	2 yrs
Due to	
Other conditions: Had a stroke of hemorrhage 7-13-46 (Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: W B Rogers M.D. M. D. or other
Address: Mt. Rainier Md. Date signed: 10.31.46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (486)

10230

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince George
City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
3709-Utah Ave, Brentwood Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3709-Utah Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Loda Jones

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Milton H. Jones
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 31-1903

8. AGE: Years	Months	Days	If less than one day
43			..... hrs. ..... min.

9. Birthplace Easton Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Juan de Gonzalez
13. Birthplace Spain
MOTHER 14. Maiden name Mary Durlin
15. Birthplace Md.
16. Informant Milton H. Jones
Address 3709-Utah Ave. Brentwood Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 12th 1946 (month) (day) (year)
Cemetery or crematory Fairfax
Location Fairfax Va.
18. Funeral director Wm. J. Valley
Address 3200-R.I. Ave. Mt. Rainier Md.
19. Oct 11 (Date rec'd by registrar) 1946 James Leary Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1946 at 12.50 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 25, 1946, to October 10 1946
and that I last saw her alive on October 10, 1946

Immediate cause of death	DURATION
Toxemia	one week
Due to Carcinoma of Uterus with metastasis.	Several months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Biopsy of left supraclavicular gland — Chest mass inguinal nodes & cervix — CA of cervix. Date of op. 8/26/46 & 8/30/46
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Mt. Rainier Md. Date signed 10/10/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-a)

CERTIFICATE OF DEATH

10231

Reg. Dist. No. 239

1. PLACE OF DEATH:

County: PRINCE George's

City or town: LAUREL

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Wash Blvd.

How long in hospital or institution? 2 mos - 28 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residenen of mother)

State: County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Donald Kalman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	

8.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5 - 1946.

8. AGE: Years | Months: 2 1/2 | Days | If less than one day: hrs. min.

9. Birthplace: Baltimore - Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Harris Kalman

13. Birthplace: New York

MOTHER 14. Maiden name: Sadie Pastel

15. Birthplace: New York

16. Informant: Mrs. Frances Greer

Address: Wash. Blvd. Laurel - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 - 7 - 46 (month) (day) (year)

Cemetery or crematory: Southern Cem

Location: Belair Rd.

18. Funeral director: Jack Lewis Jr.

Address: 1435 E. Baltimore St.

19. Sept 7 1946 M Brashears

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7th 1946, at 9:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1st 1946, to October 7th 1946

and that I last saw him alive on October 7th 1946

Immediate cause of death	DURATION
Respiratory paralysis	
Due to: Hydrocephalus	2 1/2 mos
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John Hopkins, MD

M. D. or other

Address: Laurel, Md Date signed 10/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct as to age. Name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48a)

CERTIFICATE OF DEATH

10232

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Pro Geo.
3401 Belview ave,
City or town Cheverly Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Pro Geo County
City or town Bladensburg Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3401 Belview avenue,.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alice Carrie Keeting

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife Charles W. Keeting
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 4, 1865.

8. AGE: Years	Months	Days	If less than one day
81			..... hrs. ..... min.

9. Birthplace Massachusetts
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Louis Emily
13. Birthplace Canada
MOTHER 14. Maiden name Bridget Kane
15. Birthplace Ireland
16. Informant Mrs Ina Ryan
Address 4518 Livingston Rd Washington D. C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 28, 1946 (month) (day) (year)
Cemetery or crematory F. Gasch's Sons
Location Hyattsville Maryland
18. Funeral director Fort Lincoln Cemetery
Address Washington D. C.
19. 10/27 (Date rec'd by registrar) 19 46 Amanda Deuney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 19 46, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 46, to Oct. 25 19 46
and that I last saw her alive on Oct 25 19 46

Immediate cause of death	DURATION
Carcinoma of Cervix	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address Hyattsville Md Date signed 10-26-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (191-a)

CERTIFICATE OF DEATH

★10233

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County Pr. Georges

City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
3 days
How long in hospital or institution? Pr. Georges Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Pr. Ges.

City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4508 Tuckerman St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Kirby, alexander B.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife Bertha E.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 16 - 1872

8. AGE: Years	Months	Days	If less than one day
73			..... hrs. ..... min.

9. Birthplace N. Y. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Michael Kirby

13. Birthplace Ireland

MOTHER 14. Maiden name Ellen Kearney

15. Birthplace England

16. Informant Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 2, 1946 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Maryland

18. Funeral director James T. Ryan, Inc.

Address 347 Penna. Ave., S.E.

19. 10/31 1946 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31-1946, at 6 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-19 1946, to 10-31 1946

and that I last saw h[illegible] alive on 10-30 1946

	DURATION
Immediate cause of death Cerebral Hemorrhage	4 days
Due to Hypertension Cardiac Vascular Renal Disease	3 yrs.
Due to	
Other conditions Enlarged Prostate	?

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. Bruenger M.D.
M. D. or other

Address Mt. Rainier Md. Date signed 10-31-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

10234

Reg. Diat. No. 245

1. PLACE OF DEATH:
County Prince Georges
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince Georges
City or town Riverdale Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6304 - 60th Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs Regina Louise Kohlmer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Mrs Louis Joseph Kohlmer
6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Aug 25 - 1868

8. AGE: Years	Months	Days	If less than one day
78	1	10	..... hrs. ..... min.

9. Birthplace Mass. (Town, county, and state)
10. Usual occupation House wife
11. Industry or business Own home
FATHER 12. Name Charles S. Kohner
13. Birthplace Germany
MOTHER 14. Maiden name Mary Kohner.
15. Birthplace Germany.
16. Informant Leland Memorial Hospital Records
Address Riverdale Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 8, 1946 (month) (day) (year)
Cemetery or crematory Ft. Lincoln
Location Pr. Geo. Cy. Md.
18. Funeral director W W Chambers Co.
Address Riverdale Maryland
19. Oct 6th 1946 (Date rec'd by registrar) Jaws Devery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1946, at 8:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 1946, to Oct. 5 1946
and that I last saw her alive on Oct 5 1946

Immediate cause of death	DURATION
Acute Salpingitis	very yrs
Cardiac Insufficiency	
Due to	
Cardiac Arrest	3 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE ..... M. D. or other
Address ..... Date signed 10-5-1946

M

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

BALTIMORE CITY HEALTH DEPARTMENT (170 c)

CERTIFICATE OF DEATH

Registered No. 212

09703

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Laurel, Md.
(c) Hospital or institution: Dr. Warren's hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Anne Arundel
(c) City or town: (If outside city or town limits, write RURAL and give town)
(d) Street No.: Camp Meade Road. Box 74 R.F.D. (Rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: WILLIAM H. LAWSON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Josephine Lawson
6 (c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): 1901

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: Laborer
11. Industry or business

FATHER
12. Name: John Lawson
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Lottie Crisley
15. Birthplace: Virginia

16 (a) Informant: Mrs William Lawson
(b) Address: Camp meade Rd Laurel R.F.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 29 1946 (month) (day) (year)
(c) Cemetery or crematory: Ivy Hill
Location: Laurel Md

18 (a) Funeral director: Ridgely Selby
(b) Address: 401 Main ave Laurel Md

19 (a) Oct 29 (Date rec'd by registrar) (b) Clara Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 27, 1946, at M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured Skull
Intracranial Hemorrhage
Due to Broken back

Other Conditions: Laceration & bruised lung
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: 10-26-46 at 7.30 p.m. M.
(b) Where did injury occur? Barberville, Anne Arundel Co. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? County Road While at work? No
(d) Means of injury:

23. Signature: Howard A. Mulder M.D. Medical Examiner.
Date signed: 10-28-46

VS 151

VS A15 9-45-15M

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

★ 10235

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Prince Geo. General Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince Georges
City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8704 - 48th Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mr. Harry C. Lybrand

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

B.(b) Name of husband or wife Mrs. Lillian C. Lybrand
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1890

8. AGE: Years 56 | Months 7 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace Wash. D.C. (Town, county, and state)
10. Usual occupation Retired.
11. Industry or business
FATHER 12. Name Harry C. Lybrand
13. Birthplace Pa.
MOTHER 14. Maiden name Elizabeth York
15. Birthplace Pa.
16. Informant From Chart
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 7, 1946. (month) (day) (year)
Cemetery or crematory F.H. Lincoln
Location Pr. Geo. Cy., Md.
18. Funeral director W. W. Chambers
Address 5801 Cleveland Ave, Riverdale, Md.
19. 10/5 (Date rec'd by registrar) 19 46 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1946, at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25, 1946, to Oct 3, 1946, and that I last saw h... alive on Oct 3, 1946.

Immediate cause of death	DURATION
Cerebral Coronary Occlusion	
Due to Hypertensive Heart Dis.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE Adolf Leitz M.D.
Address Hyattsville, Md. Date signed 10-3-46
M. D. or other

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

10236

Reg. Dist. No. 2342

1. PLACE OF DEATH:

County: Prince Georges

City or town: Silver Hill
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:
4764 Clifton Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Silver Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4764 Clifton Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Earl Maddox

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Hilda E Maddox

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): June 9, 1898

8. AGE: Years: 48 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Sterling Virginia
(Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: Grocery

MOTHER FATHER

12. Name: Roma F. Maddox

13. Birthplace: Sterling Va

MOTHER

14. Maiden name: Emma Hargrove

15. Birthplace: Sterling Va

16. Informant: Mrs. Hilda E. Maddox

Address: Silver Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 3rd 1946 (month) (day) (year)

Cemetery or crematory: Bellevue Church Cemetery

Location: Camp Springs Md

18. Funeral director: 2067 - Nicholson & Sons

Address

19. Oct 30 1946 (Date rec'd by registrar) Howard J Riddle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 30 1946, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute Congestive heart failure	
Due to: Alcoholism	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Deputy medical Examiner James J. Ford M. D. or other

Address: Forestville Md Date signed 10-30-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2340

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 10237

Reg. Diat. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 43 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 515 Que Street, N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Mc KINLEY CLAUDE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6.(b) Name of husband or wife: Lelia McKinley

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 12, 1908

8. AGE: Years	Months	Days	If less than one day
38	8	8	hrs. min.

9. Birthplace: Robinson County, North Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: Ellot McKinley

13. Birthplace: Robinson Co., North Carolina

MOTHER 14. Maiden name: Lou Williams

15. Birthplace: Robinson Co., North Cavolina

16. Informant: deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10-12-46 (month) (day) (year)

Cemetery or crematory: T6 Durham, N.C.

Location:

18. Funeral director: Buntley Bros. Mortuary

Address: 1510 Fayetteville St Durham N.C.

19. Oct 20 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 20 1946, at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/7 1946, to 10/20 1946 and that I last saw h. alive on 10/20 1946

Immediate cause of death: pulmonary tuberculosis — DURATION: 4 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md Date signed: 10/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2436 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10238245

1. PLACE OF DEATH:
County: Prince Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, Institution, or street address where death occurred:
Sacred Heart Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va County:
City or town: Alexandria
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 801 Duke St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Miss Margaret McWilliams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 24. 1865

8. AGE: Years: 81 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Fairfax Va (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: James McWilliams
13. Birthplace: Ireland

MOTHER
14. Maiden name: Matilda McWilliams
15. Birthplace: Ireland

16. Informant: Hospital records
Address: Hyattsville Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 18. 1946 (month) (day) (year)
Cemetery or crematory: Cunningham Funeral Home
Location: Alexandria Va

18. Funeral director: F Grachia Cox
Address: Hyattsville Md

19. Oct 18 1946 (Date rec'd by registrar) Mrs. Jas. Sweeney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1946 at 1190A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 years 19 to Oct 18 1946
and that I last saw her alive on October 18, 1946

Immediate cause of death	DURATION
Carcinoma of face with metastasis to lungs.	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thomas A Kelly M. D. or other
Address: 322 H St., N.E. Date signed: 10-18-46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1023 Reg. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 264 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 264 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1537 6th Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ALONZO MILLS

3.(b) Social Security Number: 237-14-0439

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	separated

6.(b) Name of husband or wife: Ruth Crupnp

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 3, 1911

8. AGE: Years	Months	Days	If less than one day
35	9	10	hrs. min.

9. Birthplace: Salisbury, North Carolina
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business:

FATHER
12. Name: Wyile Mills
13. Birthplace: Chester, South Carolina

MOTHER
14. Maiden name: Mary McCormick
15. Birthplace: Chester, South Carolina

16. Informant: Deceased
Address:

17. removal (Burial, cremation, or removal. Which?) Date thereof: Oct 13 1946 (month) (day) (year)

Cemetery or crematory:
Location: Washington D.C.

18. Funeral director: Francis Funeral Home Inc.
Address: 389 Rhode Island ave. N.W.

19. Oct 13 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 13 1946, at 2:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1946, to Oct 13 1946
and that I last saw him alive on Oct 13 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	19 mo
Tuberculat Laryngitis	3 mo 3 da
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)

Address: Glenn Dale, Md. Date signed: 10/13/46

2-25

2-2430

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

10240

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince Georges Co.,
City or town: Glenn Dale, Md. - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5301- Hayes St., N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: FRANCES MONROE

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	separated

6.(b) Name of husband or wife: James Monroe
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Feb. 26, 1910

8. AGE: Years	Months	Days	If less than one day
36	7	10	hrs. min.

9. Birthplace: Douglas, Georgia
(Town, county, and state)
10. Usual occupation: worker in cafeteria
11. Industry or business: -

FATHER
12. Name: John Brown
13. Birthplace: ? , Georgia

MOTHER
14. Maiden name: Rosa Bellamy
15. Birthplace: ?, Georgia

16. Informant: deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10/7/46 (month) (day) (year)
Cemetery or crematory
Location: to Washington, D.C.
18. Funeral director: John T. Rhines & Co.
Address: 901-3rd St. S.W

19. Oct. 6, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 6, 1946 at 9.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1946 to Oct. 6, 1946 and that I last saw her alive on Oct. 6, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 mo.
Complications: Tuberculous enteritis with ?	
Due to: perforation, causing acute generalized peritonitis	6 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Pulmonary tuberculosis tuberculous enteritis and perforation, acute peritonitis, generalized.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 10/6/46

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 1024 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 368 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 368 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2851 Elvans Rd., S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME MORGAN Maggie Ruth

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Marshall Morgan
6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): April 13, 1916

8. AGE: Years	Months	Days	If less than one day
30	5	18	hrs. min.

9. Birthplace: Parksville, South Carolina
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Henry Hill
13. Birthplace: Parksville, S. Carolina

MOTHER
14. Maiden name: Hetty Chamberlin
15. Birthplace: Parksville, S. Carolina

16. Informant: deceased
Address

17. removal (Burial, cremation, or removal. Which?) Date thereof Oct 1 1946 (month) (day) (year)
Cemetery or crematory:
Location: Washington D C
18. Funeral director: Johnson & Jenkins
Address: 2053 Georgia ave., N.W., Wash, D.C.
19. Oct 1 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-1 1946, at 8 52 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-28 1945, to 10-1 1946
and that I last saw h- alive on 10-1 1946

	DURATION
Immediate cause of death: PULMONARY TUBERCULOSIS	2 yrs
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 10/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1024239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Laurel, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, Institution, or street address where death occurred:
37 - 4th St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Geo
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 37 - 4th St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs S. F. Morrison

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 25, 1875

8. AGE: Years	Months	Days	If less than one day
71	4		hrs. min.

9. Birthplace: Hertford, County, N. Car.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business
FATHER 12. Name: Benjamin Franklin Early
13. Birthplace: Unknown
MOTHER 14. Maiden name: Virginia Caroline Askew
15. Birthplace: Unknown
16. Informant: Lucille Morrison
Address: Laurel, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 27. (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Union Cemetery Burial
18. Funeral director: The H. C. White Co.
Address: Laurel, Md.
19. 10-26 1946 (Date rec'd by registrar) Ora E. Waddle Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/23 1946, at 7 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/21 1946 to 10/23 1946 and that I last saw h[illegible] alive on 10/23-46 1946

Immediate cause of death: Secondary anemia
Due to: Carcinoma uterus
Septicemia
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W B Kennedy M. D. or other
Address: Laurel Date signed 10/25/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

CERTIFICATE OF DEATH

★ 10243

Reg. Dist. No. 232

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Bladensburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years 8 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Pr. George

City or town: Fairmount

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Henry F. Neitzel

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar-16-1870

8. AGE:

Years	Months	Days	If less than one day
76	7	9	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Carl Neitzel

13. Birthplace: Germany

MOTHER

14. Maiden name: Wetmund Kraebel

15. Birthplace: Germany

16. Informant: Almshouse Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-26-46 (month) (day) (year)

Cemetery or crematory: Prince Geo. Co. Almshouse

Location: Pitcher, Md.

18. Funeral director: Pitcher Brothers

Address: Upper Marlboro, Md.

19. Oct 26 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 25 1946, at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1943, to Oct 25 1946 and that I last saw h[illegible] alive on Oct 17 1946

	DURATION
Immediate cause of death: Chronic Myocarditis	?
Due to: Arteriosclerosis	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John D. Maloney M.D. M. D. or other

Address: Berwyn-Hyattsville Date signed 10-25-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

10244

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Capitol Hgts
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Capt. Hgts
(If outside city or town limits, write RURAL and give nearest town)
Street No. 104- 48 ave
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #1

3.(a) FULL NAME: JAMES HENRY OAKLEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Ethel Oakley Nee Judd
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): June 29 - 1874

8. AGE: Years: 72 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Southampton England
(Town, county, and state)

10. Usual occupation: Plaster

11. Industry or business

FATHER
12. Name: James H Oakley
13. Birthplace: England

MOTHER
14. Maiden name: Fannie Talbert
15. Birthplace: England

16. Informant: Amie Oakley
Address: 104- 48th Ave Capt. Hyts

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 10-10-46 (month) (day) (year)

Cemetery or crematory:
Location: Washington DC.

18. Funeral director: H. H. Chambers Co
Address: 517-11th St. S. E. Wash DC.

19. Oct. 10 1946 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 1946, at 7 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1946 to Oct 10 1946
and that I last saw him alive on Oct 9 1946
Immediate cause of death: cerebral edema, DURATION: 1 day
general anasarca, myocarditis,
hypertension - chronic nephritis, yrs.
Due to: Alumin transitis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W Morse MD
M. D. or other
Address: 666 Md ave N E Date signed: 10/10/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County Prince George

City or town Mt Rainer Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Mt Rainer

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3502 Perry St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Katharine Long O'Brien

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	W

6.(b) Name of husband ~~or wife~~ J. Ed. O'Brien

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 7. 1869

8. AGE: Years	Months	Days	If less than one day
77		25	..... hrs. ..... min.

9. Birthplace Montgomery, Alabama

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Dr Long

13. Birthplace Alabama

MOTHER 14. Maiden name Ila Byrd

15. Birthplace Alabama

16. Informant Mr Patrick L. O'Brien

Address 3812 Hillsdale Balt. Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Oct. 25 1946 (month) (day) (year)

Cemetery or ~~crematory~~ Fort Lincoln

Location Mt Rainer, Maryland

18. Funeral director Joseph Gawler's Sons

Address 1736 Pa. Ave. N.W.

19. Oct 23 1946 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23/46 19.... at 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 1946 to Oct 23 1946 and that I last saw ~~her~~ alive on 10/23/46 19....

Immediate cause of death	DURATION
Carcinoma of the left lung with metastases	3-6 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE James T. Burns M.D. M. D. or other

Address 1735 I St. Nw. Date signed 10/23/46


RECEIVED
OCT 25 1965
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

★10246

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince George
City or town Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, Institution, or street address where death occurred:
Leland Memorial Hospital, Riverdale Md.
How long in hospital or institution? 6 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Virginia County S. Arlington
City or town So. Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2919-6th. St. S. Arlington
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Mrs. Bertha Orrison

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Mr. Roger Temple Orrison
6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) June 13, 1877

8. AGE: Years	Months	Days	If less than one day
69	June	13	hrs. min.

9. Birthplace Portland, Maine (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Housewife
FATHER 12. Name Arthur Jordan Symonds
FATHER 13. Birthplace Portland, Maine
MOTHER 14. Maiden name Mary Augusta Barker
MOTHER 15. Birthplace New Hampshire
16. Informant Mr. Roger Temple Orrison
Address 2919-6th. St. S. Arlington, Va. (husband)
17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof 10-24-46 (month) (day) (year)
Cemetery or crematory
Location Arlington, Virginia
18. Funeral director F. GASCH'S SONS
Address HYATTSVILLE, MD.
19. Oct. 24 1946 (Date rec'd by registrar) Mrs. Joan Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1946, at 4:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21, 1946 to October 24 1946 and that I last saw h. alive on October 24, 1946

Immediate cause of death	DURATION
(a) Coronaries	18 hrs.
Due to (b) Hypertensive cardio-vascular-renal disease	8 yrs.
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

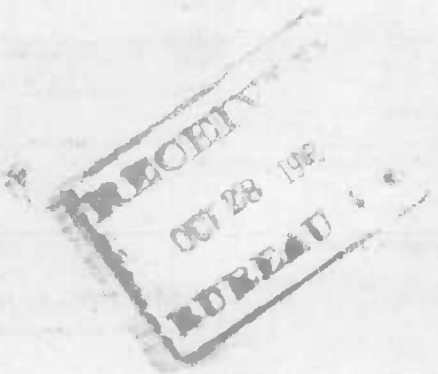
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walcutt W. Gibson, M.D.
M. D. or other
Address Riverdale, Md. Date signed Oct. 24 46

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIV
OCT 28 19
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

★ 10247

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Prince Georges

City or town Fort Washington (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

32 Washington Drive

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penn. County Washington

City or town Johnson City (If outside city or town limits, write RURAL and give nearest town)

Street No. 904-E Holston Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ella Blaine M Pence

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Edward Emmette Pence

6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) January 1, 1885

8. AGE: Years 61 | Months 10 | Days 16 | If less than one day ..... hrs. ..... min.

9. Birthplace Tennessee (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Edmond B Mitchell

FATHER 13. Birthplace Tenn.

MOTHER 14. Maiden name Amanda Gray

MOTHER 15. Birthplace Missouri

16. Informant Edward E Pence

Address 904-E Holston Ave, Johnson City Tenn

17. removal (Burial, cremation, or removal. Which?) Date thereof Oct. 16 1946 (month) (day) (year)

Cemetery or crematory Monte Vista

Location Johnson City Tenn.

18. Funeral director A H Hinds Co

Address 2901-14 St, N.W.

19. Oct 16 1946 (Date rec'd by registrar) Mrs Jas. Lovers Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1946, at 3:00 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Intra Cranial hemorrhage	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Respiratory medical Examiner

23. SIGNATURE Edward E Pence M. D. or other

Address Forestville Md Date signed 10-16-46

10248

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Prince George
City or town Oxon Hill (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Prince George
City or town Oxon Hill (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles Proctor
3. (b) Social Security Number

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mary Jane Proctor
6.(c) If alive, give age 69 years
7. Birth date of deceased (mo., day, yr.): Dec 26, 1873

8. AGE: Years 72 Months Days If less than one day ... hrs. ... min.

9. Birthplace Oxon Hill Md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name John Henry Proctor
13. Birthplace Maryland

MOTHER
14. Maiden name Olivia Ann Proctor
15. Birthplace Maryland

16. Informant Mary Jane Proctor
Address Oxon Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 23-46 (month) (day) (year)
Cemetery or crematory St. Ignatius Ch Cemetery
Location Oxon Hill - Maryland
18. Funeral director John T. Rhines & Co.
Address 901 3 St. S.W.

19. 10/19 1946 (Date rec'd by registrar) Thos I. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1946, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death Acute congestive heart failure
Due to Cardiovascular renal disease
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

Deputy medical Examiner
23. SIGNATURE James I. Boyd M. D. or other
Address Forestville Md Date signed 10-19-46

VS A15 9.45.15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

★ 10249

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince George
City or town Chevery
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, Institution, or street address where death occurred
Prince Georges General Hosp. Tal
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1829 Monroe St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sally E. Rice.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife Edward J. Rice
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 14 - 1864

8. AGE: Years 82 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore - md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name William Mc Millan
13. Birthplace md Md.

MOTHER
14. Maiden name Laura Aitcheson
15. Birthplace md Md

16. Informant Mrs. Edna Wilson
Address 1829 Monroe St. Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 2 - 1946 (month) (day) (year)
Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore - md.

18. Funeral director W. W. Chambers Co.
Address Riverdale Md.

19. 10/31 1946 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1946, at 1:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st 1946, to 10-30 1946
and that I last saw h.... alive on 10-29 1946

Immediate cause of death	DURATION
Hypertensive Renal disease + failure	4 yrs. 48 hrs.
Due to Marked Senility	
Due to	
Other conditions Fibroid Uterus.	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE A. J. Heath MD M. D. or other
Address 1933 - Monroe N.E. Date signed 11/1/46
4307 - Sheridan St. Hyattsville Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

★ 10250

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George
City or town: Hempstead Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Months
Hospital, Institution, or street address where death occurred:
6414 Talbott Pl
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince George
City or town: Hempstead Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6414 Talbott Pl.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: ESTHER CELIA (LEWIS) RINEHART

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Hebrew	Widow

6.(b) Name of husband or wife: Bernard L. Deceased
6.(c) If alive, give age: ..... years
7. Birth date of deceased (mo., day, yr.): June 7 1889

8. AGE: Years: 57 Months: 4 Days: 22 If less than one day: ..... hrs. ..... min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Home duties
FATHER 12. Name: Max
13. Birthplace: Russia
MOTHER 14. Maiden name: Ida Gould
15. Birthplace: Russia
16. Informant: Herbert A Lewis
Address: 6414 Talbott Pl.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct 29 46 (month) (day) (year)
Cemetery or crematory: Washington D.C.
Location: Goldberg Funeral Home
18. Funeral director: 4417 - 9th St NW D.C.
Address:
19. Oct 29 1946 (Date rec'd by registrar) Mrs. Jas. Severe (Registrar) (County Locals)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 29 1946 at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1946 to Oct 29 1946 and that I last saw h-er alive on Oct 29 1946

Immediate cause of death	DURATION
Terminal Cardiac decompensation	3 da
Due to: Severe generalized arteriosclerosis	2½ yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Arthur H Lewis MD (M. D. or other)
Address: 1714 R. I. Ave NW Wash, DC Date signed: 10/29/46

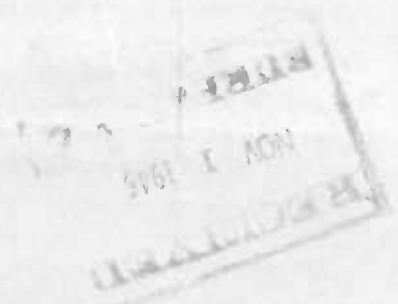
VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4309 - Farragut SS

Hepatsiwell



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-0

CERTIFICATE OF DEATH

Reg. Dist. No. 10251 240

1. PLACE OF DEATH:
County Prince Georges
City or town Brandywine Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Brandywine, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Main Highway
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ernest Gordon Robertson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Sep. 16- 1866

8. AGE: Years	Months	Days	If less than one day
80	1	2	..... hrs. ..... min.

9. Birthplace Brandywine, Md
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Farming
MOTHER FATHER 12. Name William Bruce Robertson
13. Birthplace Ft Washington, Md
MOTHER 14. Maiden name Rebecca Maria Robinson
15. Birthplace Brandywine, Md
16. Informant Ella Minerva Robertson
Address Brandywine, Md
17. Burial Date thereof 10-21-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Thomas
Location Broad Creek, Md.
18. Funeral director Tschiffely Brothers
Address Upper Marlboro, Md.
19. Oct. 19 1946 F. H. Billingsley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1946, at 8 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1946, to Oct 18 1946
and that I last saw him alive on Oct 13 1946
Immediate cause of death Aortic Stenosis & Coronary thrombosis — DURATION 6 mo
Due to Arterio Sclerosis — Indefinite
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John E. Bowers M. D. or other
Address Brandywine, Md Date signed 10/18/1946

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1025243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 44 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 44 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 458 H. Street, S. W.
(If rurel, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: NATHAN SABB

3.(b) Social Security Number: 719-01-4212

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Janice Sabb
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 12, 1901

8. AGE: Years	Months	Days	If less than one day
45	1	21	hrs. min.

9. Birthplace: Orangeburg, South Carolina
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Morgan Sabb
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Laura Johnson
15. Birthplace: South Carolina

16. Informant: deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 3, 1946 (month) (day) (year)
Cemetery or crematory
Location: to Washington, D.C.
18. Funeral director: Eugene Ford
Address: 1213 4th. St. S.W. Wash. D.C.
19. Oct 3, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 3, 1946 at 7.50 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 20, 1946 to Oct 3, 1946
and that I last saw h[illegible] alive on Oct. 2, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4½ mo.
Due to: Complication: right spontaneous pneumothorax, Bronchopleural fistula and tuberculous emphysema	1½ mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 10/3/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(*1025) Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince Georges

City or town Clinton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, Institution, or street address where death occurred: Old Alexander Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Clinton

(If outside city or town limits, write RURAL and give nearest town)

Street No. Old Alexander Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Holly Sanford

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 7, 1892

8. AGE: Years 54 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Fireman

11. Industry or business D.C. Fire Department

FATHER 12. Name Walter A Sanford

13. Birthplace Virginia

MOTHER 14. Maiden name J. Gaon

15. Birthplace Virginia

16. Informant John Holly Sanford Jr.

Address Box 47, Clinton Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof Oct 18-1946 (month) (day) (year)

Cemetery or crematory Washington Nat Cemetery

Location Suitland Maryland

18. Funeral director Thomas F Murray Funeral Home

Address 2007 Nichols Ave. S.E.

19. Oct 16 1946 (Date rec'd by registrar) Edward J Beard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1946, at 3.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to Oct 15 1946

and that I last saw h... alive on Oct 15 1946

Immediate cause of death	DURATION
Acute Congestive Heart Failure	
Due to Pneumonia	
Due to Bilateral bronchopneumonia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the followig;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Deputy medical Examiner M. D. or other

Address Forestville Md Date signed 10-15-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

10254 P

Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 M. I P
Hospital, institution, or street address where death occurred: Laurel Sanetarium
How long in hospital or institution? 8 M. I P

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: West Virginia County:
City or town: Stephenson town (If outside city or town limits, write RURAL and give nearest town)
Street No.: (If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: William Spley Short

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Martha Salesbury
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 12 - 1961

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
84	10	1		

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: Wood worker - retired
11. Industry or business:
FATHER — 12. Name: John S. Short
13. Birthplace: Baltimore
MOTHER — 14. Maiden name: Elizabeth Parker
15. Birthplace: Baltimore
16. Informant: Sanitarium Records
Address: Laurel Sanitarium, Laurel, Md.
17. (Burial, cremation, or removal. Which?) Burial — Date thereof: Oct. 16. 1946 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: 3801 Frederick Ave
18. Funeral director: John O. Mitchell & Sons
Address: 1980 Eutaw Place
19. (Date rec'd by registrar) 10/17 19 46 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 13 19 46 at 10 03 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 6 19 46 to October 13 19 46 and that I last saw him alive on October 13 19 46

Immediate cause of death	DURATION
Gangrene of foot	3 Mo
Due to: Diabetes	Unk.
Due to: General arterio sclerosis	Unk
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John L. Wetherell M D (M. D. or other)
Address: Laurel, Maryland Date signed: 10/13/46
Laurel Sanitarium

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-4)

CERTIFICATE OF DEATH

10255

Reg. Diat. No. 242

1. PLACE OF DEATH:

County: Prince George

City or town: Forestville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, institution, or street address where death occurred: Prince Georges County Almshouse

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Pr. Geo.

City or town: Mt Rainer, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Myrtle Margaret Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Wid

6.(b) Name of husband or wife: Edward Smith

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 25, 1882

8. AGE:

Years	Months	Days	If less than one day
64	8	20	hrs. min.

9. Birthplace: Rochester, N.Y.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Fred Emerson

13. Birthplace

MOTHER — 14. Maiden name: Lotta

15. Birthplace

16. Informant: Almshouse Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 9, 1946 (month) (day) (year)

Cemetery or crematory: Wash. National

Location: Suitland R.D.

18. Funeral director: W. W. Chambers

Address: Riverdale, Md

19. 10-6-1946 (Date rec'd by registrar) Thos. O. Griffith, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 5 1946, at 5.45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1941 to Oct 5 1946 and that I last saw h alive on Sept 25 1946

Immediate cause of death: Acute Cardiac Dilatation — DURATION: Sudden

Due to: Chr. Myocarditis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John J. Malarney M.D. M. D. or other

Address: Cheverly-Hyattsville Date signed: 10-6-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 10256 239

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4M 7D
Hospital, institution, or street address where death occurred:
Laurel Sanitarium
How long in hospital or institution? 4M 7D

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District Columbia County: Son
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2400 Old Bennings Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME James William B. Stead

3.(b) Social Security Number

4. Sex	5. Color or Race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Edna K Lake
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 9 - 1860

8. AGE: Years	Months	Days	If less than one day
86	5	6	..... hrs. ..... min.

9. Birthplace: Alabama (Town, county, and state)
10. Usual occupation: Employee of Veterans Bureau. (Retired)
11. Industry or business:

FATHER
12. Name: William B. Stead
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Sarah Blackburn
15. Birthplace: North Carolina

16. Informant: Sanitarium Records
Address: Laurel Sanitarium Laurel, Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10 15 46 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.

18. Funeral director: Joe Hawkins Sons
Address: 1756 Penn ave. N.W.

19. Oct 15 1946 M. Brashears (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15 1946 at 8 32 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1946 to October 15 1946 and that I last saw h[illegible] alive on October 15 1946

Immediate cause of death	DURATION
(a) Cardiac Decompensation	4M 7D
Due to: (b) Senile Arteriosclerosis	Unk
Due to: (c)	
Due to: (d)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John L. Wetherell M.D. M. D. or other
Address: Laurel Sanitarium Laurel Md Date signed 10/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

138

★ 10257

Reg. Diat. No. 2431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 3 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 mo., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 507 - F. St. N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: ENNIS, SULLIVAN

3.(b) Social Security Number: 223-24-9453

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Janet W. Sullivan

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): August 25, 1905

8. AGE:	Years	Months	Days	If less than one day
	41	1	29	...hrs. ...min.

9. Birthplace: Stafford, Virginia
(Town, county, and state)

10. Usual occupation: Bar Tender

11. Industry or business:

FATHER 12. Name: Robert M. Sullivan

13. Birthplace: Stafford, Virginia

MOTHER 14. Maiden name: Lillie Belle Sullivan

15. Birthplace: Stafford, Virginia

16. Informant: Decedent

Address:

17. removal (Burial, cremation, or removal. Which?) Date thereof: 10 - 26 - 46 (month) (day) (year)

Cemetery or crematory:

Location: Fredericksburg, Va.

18. Funeral director: Wheeler & Thompson

Address: Fredericksburg Va.

19. Oct 24 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 24th 1946, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 21st 1946, to Oct 24th 1946, and that I last saw him alive on Oct 24, 1946 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	12 yrs
Due to:	
Due to: Complications: Tuberculous entero-colitis	10 da.
Other conditions: Spontaneous pneumothorax, mediastinal emphysema	3 da.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glen Dale, Md. Date signed: 10/24/46

2-25

2-2430

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75a)

CERTIFICATE OF DEATH

10258

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 min.
Hospital, institution, or street address where death occurred:
Prince Georges General Hospital
How long in hospital or institution? 45 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Glenndale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: THOMAS TAYLOR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katherine Taylor
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 1, 1875

8. AGE: Years	Months	Days	If less than one day
71			..... hrs. ..... min.

9. Birthplace: England
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER — 12. Name: Thomas Taylor
13. Birthplace: England

MOTHER — 14. Maiden name: Emma ?
15. Birthplace: England

16. Informant: George Ruth
Address: Glenndale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 19/46 (month) (day) (year)
Cemetery or crematory: St. Georges
Location: Glenndale, Md.
18. Funeral director: F. Gasch's Sons
Address: Hyattsville, Md.

19. 10/18 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 17 1946, at 12:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7, 1944 19..., to Oct 17 1946
and that I last saw h... alive on Oct 16 1946

Immediate cause of death	DURATION
Arterial fibrilation (90a)	3 yrs
Due to: Hypertention (102)	6 yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Robert D McCrory M.D. or other
Address: 40 Main St Laurel Md Date signed 10/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

Reg. Diat. No. 10259 45

1. PLACE OF DEATH:
County: PRINCE GEORGE
City or town: RIVERDALE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year 7 mo.
Hospital, institution, or street address where death occurred:
LELAND MEMO.
How long in hospital or institution? 1 year 7 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4115 - 13th Place N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Edith J. R. Tippett

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	White	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): MARCH 11 1869

8. AGE: Years	Months	Days	If less than one day
77			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Surpervisor Burk Engraving.
11. Industry or business: U.S. Gov.

FATHER
12. Name: PHILLIP FRANKLIN
13. Birthplace: Maryland

MOTHER
14. Maiden name: MARGARET V. TOWNSHEND
15. Birthplace: Maryland.

16. Informant: Mrs Margaret A. Tippett Finn
Address: 4115 13th Place N.E. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10 11 1946 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetry
Location: Suitland, Md

18. Funeral director: J. William Leis Son
Address: 306 - 4 St N.E. D.C.

19. Oct 14 1946 (Date rec'd by registrar) Jams Devot Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 14 1946, at 10 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1945, to Oct 14 1946 and that I last saw h alive on Oct 13 1946

Immediate cause of death	DURATION
Cerebral Thrombosis	
Cerebral Hemorrhage during past 6 mos.	
Due to: Hypertention.	3+ years
Due to:	
Other conditions: Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Richard F Shaw MD M. D. or other
Address: 1324 Quincy Ave NE D.C. Date signed: 10-14-46

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

10260

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15

1. PLACE OF DEATH:
County: Prince Geo.
City or town: Hillside md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Hillside
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1322 57th ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: GERTRUDE TUOHY

3.(b) Social Security Number: 579-03-9150A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: MICHAEL M TUOHY
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 13th 1874

8. AGE: Years	Months	Days	If less than one day
72			..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business: none
FATHER 12. Name: James H. Dennison
13. Birthplace: Maryland
MOTHER 14. Maiden name: Harriette Weaver
15. Birthplace: Maryland
16. Mrs. Margaret L. Spencer
Address: 1322 57th ave Hillside md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-21-46 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland, md.
18. Funeral director: W. W. Chambers Co.
Address: 517 11th St. S. E.
19. Oct. 18 1946 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 17th 1946, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Oct 17 1946 and that I last saw her alive on Oct 17 1946

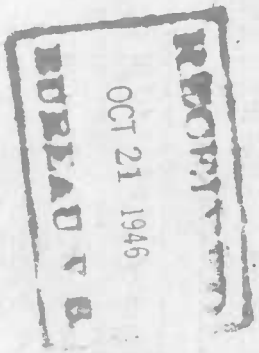
	DURATION
Immediate cause of death: Acute Cardiac failure —	1 day
Due to: Chronic Hypertension and General Arteriosclerosis —	3 Weeks
Due to:	unknown
Other conditions: Cancer enlarged left breast with metastases	5 years

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op. —
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide: no Date of —
Where did injury occur? no (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Washington 19 DC Date signed: Oct 18 1946



VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

10261

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince George

City or town Broad Creek Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo

Hospital, Institution, or street address where death occurred:
6 mo

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Prince George

City or town Broad Creek
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7250 Livingston Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME DOROTHY R WAGNER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femal	White	Married

6.(b) Name of husband or wife Boyd R Wagner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 18th 1916

8. AGE: Years 30 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Prince George County Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

FATHER 12. Name JOHN A RUSSELL

13. Birthplace MD

MOTHER 14. Maiden name DOROTHY THORNE

15. Birthplace Prince George MD.

16. Interment BOYD R WAGNER

Address 7250 Livingston Rd.

17. Burial Date thereof 10-19-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Bladensburg. Md.

18. Funeral director W. W. Chambers Co.

Address 517 11th St S.E.

19. 10/17/46 Carrie F. Campbell
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16-1946, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 6 1946 to Oct. 16 1946 and that I last saw h er alive on Oct. 16 1946

Immediate cause of death	DURATION
Uremia	2 wks.
Due to Chr. cardio-vascular-renal disease	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE Robert L. Cooper M.D.
M. D. or other

Address 2210 Nichols Ave., S.E., Washington 20, D.C. Date signed 10/16/46

is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

14262

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George Co,
City or town: Hyattsville R F D, (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Days
Hospital, Institution, or street address where death occurred: Mother Jones Rest Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montg.,
City or town: Germantown. Md,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Martha Jane Wallich

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Basil C. Wallich
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 3rd 1868

8. AGE: Years	Months	Days	If less than one day
1868 78	3	19	hrs. min.

9. Birthplace: Germantown. Md,
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER
12. Name: Richard Bennett
13. Birthplace: Md,

MOTHER
14. Maiden name: Savilla Mills
15. Birthplace: Md,

16. Informant: Richard Wallach
Address: Germantown Md,

17. (Burial, cremation, or removal. Which?) Burial Date thereof 10/25/46 (month) (day) (year)
Cemetery or crematory: CEDAR HILL CEMETERY
Location: Near, Washington D C,

18. Funeral director: Ernest C. Gartner
Address: Gaithersburg Md,

19. Oct. 24" 1946 (Date rec'd by registrar) Mrs. Jas. Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 1946 at 10 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 25 1946, to October 22 1946
and that I last saw her alive on October 22 1946

Immediate cause of death	DURATION
Heart disease, arteriosclerosis, with decompensation and pulmonary congestion.	1 yr.
Due to: ARTERIOSCLEROSIS, generalized	20 yrs.
Due to: Senility	20 yrs.
Other conditions: Paralysis (Hemiplegia, Rt. Side, complete)	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Geo. Kelly, M.D. M. D. or other
Address: Dawsonville, Md. Date signed 23 Oct. '46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-C)

CERTIFICATE OF DEATH

10263

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges

City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Prince Geo. Gen. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D. C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2913 Denver St., S. E.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Anna Elizabeth Walter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	w	S

6.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 4 hrs. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name Norman Walter

FATHER — 13. Birthplace —

MOTHER — 14. Maiden name Elizabeth Barrett

MOTHER — 15. Birthplace Ireland

16. Informant Mr. Norman Walter

Address above same.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 29 1946 (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Wash. D.C.

18. Funeral director James T. Ryan Inc.

Address 317 P Pennsylvania Ave S E.

19. 10/28 1946 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Intrapartem Asphyxia	
Due to Collapse of cord	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Francis Warren, M.D.
M. D. or other

Address 1246 K St. N.W. Date signed 10/28/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-P)

CERTIFICATE OF DEATH

10269

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: Hyattsville md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 5019 - 56th Ave Rodgers Hgts.

Stay in hospital or Inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: OHIO County: STARK

City or town: CANTON Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 918 - SPRING ST.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: MARTHA MABEL WALTON

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	WHITE	WIDOW

6 (b) Name of husband: OLIE WALTON

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): SEPT. 7 - 1885

8. AGE:

Years	Months	Days	If less than one day
61			hrs. min.

9. Birthplace: OHIO (Town, county, and state)

10. Usual occupation: NONE

11. Industry or business: —

FATHER — 12. Name: Jacob EUTZLER

FATHER — 13. Birthplace: SWITZERLAND

MOTHER — 14. Maiden name: MATTI, CATHERINE

MOTHER — 15. Birthplace: SWITZERLAND.

16. Informant: Mrs Gladys Watts

Address: 5019 - 56th Ave Rodgers Hgts.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 9 1946 (month) (day) (year)

Cemetery or crematory: Bethel, Overton, Ohio

Location: Overton, Ohio

18. Funeral director: H. H. Chambers Co

Address: Riverdale maryland

19. Oct 7th 1946 (Date rec'd by registrar) Amanda Mooney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 6th 1946, at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-19-46 19 to 10-6 1946, and that I last saw her alive on 10-5-46 19

Immediate cause of death	DURATION
Carcinoma of liver	9 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John P. Cann M.D. M. D. or other

Address: Hyattsville Md Date signed: 10-6-46

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-6)

10264

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince George
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 hours.
Hospital, institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution? 24 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince George
City or town College Park.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4500 College Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William E. White

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W. Lawd

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 30 - 1870

8. AGE: Years 76 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace England
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER
12. Name James White
13. Birthplace England
MOTHER
14. Maiden name Mary Ann Pinchini
15. Birthplace England

16. Informant Mrs Mary E Chaney - Daughter
Address 4500 College Ave College Pk

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 13, 1946 (month) (day) (year)
Cemetery or crematory St Johns Cemetery
Location Bellevile Md

18. Funeral director F Gaschè sons
Address Hyattsville Md

19. 10/12/46 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 10 19 46, at 12 20 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7 19 46, to Oct 10 19 46
and that I last saw h~~im~~ alive on October 10 19 46

Immediate cause of death Intestinal Obstruction with Gangrene & Suti. — DURATION 3 dys
Due to Peritoneal Bands — old
Due to
Other conditions Myocardiacs Cordis (healed) old
(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results Same -
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. Louis Mendel M.D. M. D. or other
Address College Park, Md Date signed 10/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10265

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale - RURAL
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city of town limits, write RURAL and give nearest town)

Street No. 315- L. St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ELIZA WHITTAKER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Turner Whittaker

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 4, 1900

8. AGE: Years	Months	Days	If less than one day
46	7	22	hrs. min.

9. Birthplace: ? - N. Carolina
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: -

FATHER
12. Name: Edward Tillery
13. Birthplace: ? , N. Carolina

MOTHER
14. Maiden name: Maria Dumory
15. Birthplace: ? , N. Carolina

16. Informant: deceased
Address

17. (Burial, cremation or removal. Which?) Removal Date thereof: Oct 27 1946 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: E. Harvey Funeral Home

Address: 306 L. St. N.E.

19. (Date rec'd by registrar) Oct. 26, 1946 Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 26, 1946, at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 15, 1946, to Oct. 26, 1946, and that I last saw h- alive on Oct. 26, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 Mo's
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 10/26/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-25

2-2430

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

10266

Reg. Dist. No. 232

1. PLACE OF DEATH:

County: Prince Georges

City or town: Forestville, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Geo -

City or town: Forestville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Pr. Geo County Almshouse

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Marcelus Willett.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	W. divorced

6.(b) Name of husband or wife: Adelaide Robey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 10, 1864

8. AGE: Years: 82 Months: 8 Days: 4 If less than one day: ..... hrs. ..... min.

9. Birthplace: White Plains, Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER

12. Name: Geo. Washington Willett

13. Birthplace: White Plains, Md

MOTHER

14. Maiden name: Sally Ann McDonalt

15. Birthplace: White Plains, Md.

16. Informant: Almshouse Records.

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-30-46. (month) (day) (year)

Cemetery or crematory: Pr. Geo. Co. Alms House

Location: Forestville, Md

18. Funeral director: Ritchie Brothers

Address: White Marsh, Md

19. Oct 29 46 (Date rec'd by registrar) 19.....

R. C. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 27 19 46, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 41, to Oct 27 19 46

and that I last saw h.. alive on Oct 25 19 46

Immediate cause of death	DURATION
Hemorrhage	Sudden
Due to: Carcinoma of face	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John J. Maloney M.D. M. D. or other

Address: Upper Marlboro, Md Date signed 10-28-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


OCT 30 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

10267

Reg. Dist. No. 232

1. PLACE OF DEATH:

County: Prince Georges

City or town: Camp Springs
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Immediate

Hospital, Institution, or street address where death occurred:
Army Air Field

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Maple Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Walter Edward Woolgar

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jeanette J. Woolgar

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): March 31, 1883

8. AGE: Years: 63 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Brighton, England
(Town, county, and state)

10. Usual occupation: Plasterer

11. Industry or business: Building

FATHER
12. Name: Walter Woolgar
13. Birthplace: England

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Fredrick E. Woolgar

Address: Upper Marlboro, Md.

17. Interment
(Burial, cremation, or removal: Which?)
Date thereof: 10-16-46.
(month) (day) (year)

Cemetery or crematory: Unknown Brothers

Location: Washington, Long Island, N. Y.

18. Funeral director: Tuckie Brothers

Address: Upper Marlboro, Md.

19. Oct 15 19 46
(Date rec'd by registrar)
C. Rue Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 14 19 46, at 1:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy Medical Examiner James D. Lamb M. D. or other

Address: Forestville, Md. Date signed: 10-15-46

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VS. A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-C

10268

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:
County Prince Georges
City or town Laurel - Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
307 Prince Geo. St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State — County —
City or town —
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Gregory Neil Wuyster

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 26, 1946

8. AGE: Years | Months | Days: 18 | If less than one day: ..... hrs. ..... min.

9. Birthplace Laurel P.G. Co Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER — 12. Name Cornelius C. Wuyster
13. Birthplace Baltimore Md.

MOTHER — 14. Maiden name Jeannette Willow
15. Birthplace Mongola Ill.

16. Informant C. C. Wuyster
Address 815 Main St. Laurel Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct. 17 1946 (month) (day) (year)
Cemetery or crematory London Park
Location Baltimore Md.

18. Funeral director H. E. Wiltshire & Sheldon
Address Laurel Md.

19. Oct 17 1946 M. Brashears
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1946, at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 26 1946 to Oct 14 1946 and that I last saw him alive on Oct 14 1946

Immediate cause of death	DURATION
Premature birth	3 hrs
6 mos Gestation	
Due to Premature	
Ruptured Membranes	
Due to Breech Presentation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE J. M. Warren MD
M. D. or other
Address Laurel Date signed 10-14-46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING